STATE OF TENNESSEE

DEPARTMENT OF COMMERCE AND INSURANCE

TENNCARE DIVISION

and

THE OFFICE OF THE COMPTROLLER OF THE TREASURY

DIVISION OF STATE AUDIT

MARKET CONDUCT EXAMINATION

and

LIMITED SCOPE FINANCIAL AND COMPLIANCE EXAMINATION

of

PREFERRED HEALTH PARTNERSHIP OF TENNESSEE, INC.

KNOXVILLE, TENNESSEE

FOR THE PERIOD JANUARY 1, 2000 THROUGH DECEMBER 31, 2000

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FROM: Paul Lamb, CPA, TennCare Manager
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DATE: December 12, 2002

SUBJECT: Limited Scope Financial and Compliance Examination and Claims Processing Market Conduct Examination of Preferred Health Partnership of Tennessee, Inc.

A limited market conduct examination of claims processing and a limited scope financial and compliance examination of Preferred Health Partnership of Tennessee, Inc., 1420 Centerpoint Boulevard, Knoxville Tennessee, 37932, was completed May 25, 2001. The report of this examination is herein respectfully submitted.

I. FOREWORD

This report reflects the results of a market conduct examination report "by test" of the claims processing system of Preferred Health Partnership of Tennessee, Inc. (PHPT). A description of the specific tests applied is set forth in the body of this report and the results of those tests are included herein. Further, this report reflects the results of a limited scope examination of financial statement account balances as reported by PHPT and of PHPT's compliance with certain contractual and statutory requirements.

II. PURPOSE AND SCOPE

A. Authority

This examination of PHPT was conducted jointly by the TennCare Division of the Tennessee Department of Commerce and Insurance (TDCI) and the Office of the Comptroller of the Treasury, Division of State Audit (Comptroller) under the authority of Section 3-6. of the TennCare contract between the State of Tennessee and PHPT, Executive Order No. 1 dated January 26, 1995, and Tenn. Code Ann. § 56-32-215.

PHPT is licensed as a health maintenance organization (HMO) in the state and participates by contract with the state as a managed care organization (MCO) in the TennCare Program. The TennCare Program is administered by the TennCare Bureau within the Tennessee Department of Finance and Administration.

B. Areas Examined and Period Covered

The market conduct examination focused on the claims processing functions and performance of PHPT. The examiners selected 35 claims for testing from paid and denied claims processed by PHPT from January 1, 2000, through June 30, 2000. The examiners also selected 25 claims for testing from paid and denied claims processed during the month of October 2000. The fieldwork was performed from February 23, 2001, through March 9, 2001, and from May 24 through May 25, 2001.

The limited scope financial examination focused on the balance sheet and income statement included in PHPT's National Association of Insurance Commissioners (NAIC) Annual Statement for the year ended December 31, 2000.

The limited scope compliance examination focused on PHPT's provider appeals, review of provider agreements and subcontracts, and demonstration of compliance

with Federal Title VI of the 1964 Civil Rights Act, the required statutory filings for HMO holding companies and the medical loss ratio report.

C. Purpose and Objective

The purpose of the examination was to obtain reasonable assurance that PHPT's operations were administered in accordance with the TennCare Contract and state statutes and regulations concerning HMO operations, thus reasonably assuring that PHPT TennCare members receive uninterrupted delivery of health care services on an on-going basis.

The objectives of the examination were to:

- Determine whether PHPT met its contractual obligations under its Contractor Risk Agreement with the state (the "TennCare Contract") and whether PHPT was in compliance with the regulatory requirements for HMOs set forth in Tenn. Code Ann. § § 56-32-201 *et seq.*;

- Determine whether PHPT had sufficient financial capital and adequate risk reserves to ensure the uninterrupted delivery of health care services for its TennCare members on an on-going basis;

- Determine whether PHPT properly adjudicated claims from service providers and made payments to providers in a timely manner;

- Determine whether PHPT had corrected deficiencies outlined in prior reviews of PHPT conducted by the Comptroller or examinations conducted by TDCI.

III. PROFILE

A. Brief Overview

Preferred Health Partnership of Tennessee, Inc., was chartered in the state of Tennessee on September 3, 1993, for the purpose of providing managed health care services to individuals participating in the state's TennCare Program. PHPT is a wholly-owned subsidiary of PHP Companies, Inc. (PHP), which also owns other health insurance and insurance-related subsidiaries and is itself a majority-owned subsidiary of Covenant Health.

On January 1, 1994, PHPT contracted with the state as a preferred provider organization. On December 31, 1996, TDCI granted PHPT a certificate of authority to operate as an HMO.

PHPT is currently authorized by TDCI and the TennCare Bureau to operate in the community service areas of Knox County, Hamilton County, First Tennessee, Southeast, and East Tennessee. PHPT derives the majority of its revenue in the form of capitation payments from the state for providing medical benefits to TennCare members. As of December 31, 2000, PHPT reported 97,816 TennCare members.

B. Claims Processing Not Performed by MCO

PHPT subcontracted with the following vendors for the provision of specific TennCare benefits and the processing and payment of related claims submitted by providers:

- Express Scripts, pharmacy benefits manager,
- Quality Transportation, Inc., transportation services, and
- Doral Dental, dental services.

Because subcontractors processed the claims for these benefits, claims for these types of services were not included in the population of PHPT claims from which 60 claims were selected for detailed testing**.**

IV. PREVIOUS EXAMINATION FINDINGS - CLAIMS PROCESSING

The following were claims processing and internal control deficiencies cited in the examination by the Comptroller of the Treasury, Division of State Audit, for the period January 1, 1998, through June 30, 1999, released July 31, 2000. PHPT responded to the findings on June 28, 2000.

Deficiencies in Claims Processing System

PHPT did not fulfill contract reporting requirements and processing efficiency requirements. Four claims were not paid in accordance with the negotiated rates. Five claims did not have all data elements recorded in the system. One claim was appropriately denied but the wrong code was reported. One claim was paid when it should have been denied. Two claims were denied but not all the denial codes were present in the system. One claim was denied incorrectly. The claim processing system did not appear to accumulate out-of-pocket amounts. Not all the requested information was provided to the auditors.

PHPT's response: "*Management concurs with the audit recommendations with one exception. Our Amisys software system reports one reason for claims denial when a claim is adjudicated as a denial. Configuration and reprogramming of our systems to add all possible reasons for denial on the remittance advice to provider is not economically feasible.*

We concur that claims should be paid according to the correct fee schedule or contract pricing methodologies. Significant work is ongoing to insure our claims systems price services paid at the appropriate level of reimbursement. We will be matching our provider fee schedules to extracts from our claims processing systems to guard against manual data errors in the loading of fee schedule information.

Management concurs that all data elements required for individual encounter/claims data reporting should be recorded from claims submitted by providers. Some errors, those related to incorrect dates, identified in the audit were a result of human intervention to redirect claims that had been loaded to the wrong claims processing system. These errors were most frequent during the transition from our CSC MHC claims processing system to the Amisys claims processing system effective January 1, 1999.

As we continue to see fewer claims with dates of service prior to this date, the opportunity for these errors will be minimized. We are also working on electronic sorting capabilities for images loaded to our Macess electronic imaging and workflow system. These improvements should enhance our efficiency in the mail and avoid human error in the mail sorting process.

Errors related to omitted diagnoses codes on the claims identified were a result of human error. Our training has been updated to re-emphasize the need to capture all diagnoses. We do have a system limitation of 3 diagnoses for medical claims and 15 diagnoses for hospital claims.

We concur with the requirement that claims be paid or denied within timeframes required by the TennCare contract. Our processing efficiency has improved significantly with the Amisys system, but we have been guilty of holding claims in a pended status in an attempt to obtain additional information to properly adjudicate a claim when initially submitted. We will be more conscious of the contract deadlines and deny claims for lack of information as appropriate when timeframes dictate.

Management concurs with the need to track out-of pocket expenses. On 1/1/97 PHPT TennCare entered into an alternative cost sharing arrangement with the Bureau for our members. This arrangement requires no deductibles, as the members have straight copays for doctor office visits, hospital emergency room and pharmacy. Pharmacy data is not housed on the Amisys system due to a subcontracted vendor arrangement. Because of this,

copay tracking is done through the PHPT TennCare data warehouse. It is our understanding that the BHO has not been enforcing cost sharing responsibilities for members and therefore there is no out of pocket data to place in the warehouse for tracking purposes. Through a data extract at the for paid claims in 1999, it was identified that no PHPT TennCare member had met or exceeded the $1,000 dollar out of pocket limit. We will continue to monitor the out of pocket amounts of our membership throughout 2000 on a regular basis.

Copies of explanation of benefits or remittance advices were mailed to the Comptroller Office two weeks after the examination. These were provided at a later time due to the need to request copies from Perot."

Deficiencies in Provider Contract Language

Not all provider agreements contained all the provisions required under Sections 2-18 of the TennCare Contract.

PHPT's response: *"Management acknowledges that at the beginning of the audit period, some of the provider agreements did not contain all of the TennCare contractually required language. Amendments were sent to all PHPT TennCare participating providers in the fall of 1998 (the September 1998 Amendment) which complied with all necessary TennCare contract language stipulations. The provider agreement templates were revised and updated with all the regulatory language additions, changes and deletions. Current provider templates and any new provider or organizational entity contracts reflect the changes to the TennCare Risk Agreement and the provisions that are contained within that Agreement and the Amendments to that Agreement."*

V. SUMMARY OF PERTINENT FACTUAL FINDINGS

A. Summary of Deficiencies – Claims Processing

The following deficiencies were determined to exist during the market conduct examination of PHPT for the period January 1, 2000, through December 31, 2000:

1. PHPT did not process claims in accordance with the TennCare Contract. Only 95% of all claims in the sample were processed within 60 days. The TennCare contract requires an MCO to process 100% of all claims within 60 days.

2. Three claims were not paid in accordance with the appropriate fee schedule.

3. One denied claim did not list all of the appropriate denial codes.

4. Keying errors for two provider claims incorrectly created deductibles. One claim showed a deductible of $0.08 and one claim showed $1,500. Furthermore, PHPT did not pay the provider for a claim. The allowed amount and the deductible were equal.

5. The claims processing system did not correctly calculate a copay for one enrollee.

6. PHPT did not provide EOBs for 8 claims.

7. PHPT did not provide the remittance advice (explanation of plan) for 1 claim.

8. Seven claims did not have all the diagnosis codes from the claim entered in the claims processing system.

9. The pend report reviewed indicated 64 claims in a suspended status for more than 60 days. The TennCare contract requires that 100% of all claims be processed within 60 days.

B. Summary of Deficiencies – Limited Scope Financial and Compliance Examination

The following deficiencies were determined to exist during the limited scope financial and compliance examination of PHPT for the period ended December 31, 2000:

1. PHPT did not respond timely to appeals received from providers. PHPT took longer than 60 days to resolve 55 of 82 provider appeals reviewed.

2. PHPT did not obtain an actuarial certification of three liabilities (Reserve for Transplants, Accrued Run Out Cost, and Grier Decree Reserve) and one loss contingency (Reserve for Contingent Operating Losses) reported on its NAIC 2000 Annual Financial Statement.

3. PHPT incorrectly reported rebates from its pharmacy provider as miscellaneous income.

4. PHPT incorrectly reported IBNR medical expense as a single line item in the NAIC Annual Statement.

5. The “Accounts Receivable-UPA” account was overstated by $7,721.

6. PHP did not submit its administrative services contract with PHP to the TennCare Bureau for approval.

7. PHPT did not pay all subcontractors timely in accordance with the terms of the subcontract.

8. PHPT did not submit the required statutory filing relative to the HMO holding company system by the date due.

VI. DETAIL OF TESTS CONDUCTED - CLAIMS PROCESSING SYSTEM

A. Claims Selected For Testing

PHPT provided the examiners a data file of paid and denied claims for the period January 1 through June 30, 2000, and for October 2000.

For each claim processed, the data file included the amount paid or an explanation of the reason for denial. From the data files, the examiners judgmentally selected 60 claims for testing as follows:

- 20 claims were selected due to the high occurrence of the same explanation code in the data file from the January to June data file;
- 3 large dollar claims were selected from the January to June data file;
- 4 claims with deductibles were selected from the January to June data file;
- 4 claims with co-payments were selected from the January to June data file;
- 3 emergency room claims were selected from the January to June data file;
- 1 claim was selected as an example of a denied claim for emergency room services; and
- 25 claims were selected at random from the October data file.

For the October 2000 data file only, the examiners reconciled the total payments to the PHPT check registers and debit memos issued for the month. (A "debit memo" is a claim payment applied against an outstanding balance a provider owes to PHPT.) Payments per the data file reconciled to within 6% of the totals of the check registers and debit memos. The variance was determined not to materially impact the results of the test.

B. Julian Date Testing

A Julian date is assigned to an incoming claim to indicate the date the claim was received. Julian dates entered in the claims processing system were tested to ensure that claims were aged accurately for timeliness reporting. Ten claims were randomly

selected from a batch of incoming mail on February 27, 2001. By March 6, 2001, these 10 claims had been entered into the claims processing system with the correct received date.

C. Time Study of Claims Processing

1. The purpose of conducting a time study of claims is to determine whether claims were adjudicated within the time frames required by Section 2-18. of the TennCare Contract and Tennessee Code Annotated § 56-32-226(b) (the "Prompt Pay Act"). Section 2-18. of the TennCare Contract requires an MCO to process 95% of "clean" claims within 30 calendar days of receipt, the remaining 5% of "clean" claims within the next 10 calendar days, and 100% of *all* claims ("clean" or not "clean") within 60 calendar days of receipt. A "clean" claim is defined as a claim which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by the MCO. The term "process" means that the MCO must either:

   - Pay the claim (the MCO shall either send the provider cash or cash equivalents in full satisfaction of the clean claim, or give the provider a credit against any outstanding balance owed by the provider to the MCO);

   - Deny the claim, with **all specific reasons** for the denial communicated to the provider; or

   - Advise the provider that there is insufficient information to adjudicate the claim and detail the specific information needed to adjudicate the claim.

   The Prompt Pay Act requires that 90% of clean claims be processed, and if appropriate paid, within 30 days of receipt and that 99.5% of all provider claims be processed within 60 days of receipt.

   The processing and efficiency requirements of the TennCare Contract were applied to the 60 claims tested. Since it could not be determined from the claims system if a claim was a clean claim, all sixty claims were considered clean.

   For denied claims, the date that the provider remittance advice was printed was considered the final process date. For paid claims, the date printed on the check plus four additional days for processing before mailing was considered the final process date.

The timeliness testing applied to the 60 selected claims found that PHPT did not process all claims within 60 days from receipt of the claim. The TennCare Contract requires 100% of all claims be processed within 60 days of receipt.

Because the 60 claims tested were not selected using a statistical sampling method, the results of the timeliness test for processing clean claims could not be projected to the total population of claims processed by PHPT during the period January 1 through June 30, 2000, and for October 2000. Therefore, it was not determined whether, during the test period, PHPT complied with the TennCare Contract requirements to process 95% of clean claims within 30 days of receipt and the remaining 5% of clean claims within the next 10 days of receipt.

PHPT's Response: Management concurs. Based upon the last several months of claims files sent to the Bureau, there are 0% of clean claims processed over 60 days.

TDCI Rebuttal: The results of the prompt pay analysis for all medical claims paid in July 2002 indicated that 0.03% of these claims were aged over 60 days. Because PHP exceeded the 99.5% requirement for prompt pay, PHP satisfied the statutory requirements of the Prompt Pay Act for July 2002.

2. On October 31, 2000 and April 12, 2001, TDCI requested a data file from the TennCare MCOs containing **all** claims processed during the months of October 2000 and April 2001 respectively. TDCI used these data files to determine each MCO's compliance with the processing requirements defined in TCA § 56-32-226(b) and Section 2-18. of the TennCare Contract by calculating the processing time lag based on the claims' received and processed dates. Because these tests were performed on all claims processed in October 2000 and April 2001, projection of the test results to the population was not necessary.

   During the month of October 2000, PHPT processed 96.6% of all claims within 30 days and 98.6% of all claims within 60 days. During the month of April 2001, PHPT processed 86.1% of all claims within 30 days and 99.8% of all claims within 60 days.

   TCA § 56-32-226(b) requires that 90% of all claims be processed within 30 days and 99.5% of all claims be processed within 60 days. Section 2-18 of the TennCare Contract requires that 100% of all claims be processed within 60 days. PHPT was not in compliance with either TCA § 56-32-226(b) or Section 2-18 of the TennCare Contract.

Because PHPT did not comply with the Prompt Pay Act for claims processed during October 2000 and April 2001, TDCI requested a data file from PHPT containing all claims processed during the month of May 2001. During the month of May 2001, PHPT processed 91.2% of all claims within 30 days and 99.97% of all claims within 60 days. PHPT was in compliance with TCA § 56-32-226(b) for the month of May 2001; however, it was not in compliance with Section 2-18. of the TennCare Contract because .03% of claims were not processed within 60 days of receipt.

It should be noted that effective July 1, 2001, the timeliness requirements in the TennCare Contract have been changed to be consistent with those set forth in the Prompt Pay Act.

PHPT's Response: Management concurs. We are currently exceeding the regulations outlines found in the Prompt Pay Act as they specifically relate to claims paid within 30 and 60 days of receipt.

D. Adjudication Accuracy Testing

The purpose of adjudication accuracy testing is to determine if claims selected were properly paid, denied, or rejected. Results of the adjudication testing are as follows:

1. Three claims were paid at a rate that did not agree with the payment rates established by the provider contract. It appears that the claims were paid from the wrong fee schedule.

   PHPT's Response: Management concurs. Fee schedule auditing is now being conducted by our own Internal Audit department. Also, an electronic database (E-flex) which will clearly detail all the fee schedules will be implemented company wide on 01/01/03. An audit is currently being conducted on this database to ensure all listed schedules are accurate.

2. One denied claim listed only one denial code when it should also have been denied for "submit charges to state TennCare Nashville." The enrollee was a dual Medicare/Medicaid eligible and the coinsurance should have been billed to TennCare.

   PHPT's Response: Management concurs. Due to our high auto adjudication rates, denials are done electronically and systematically. The payment hierarchy in Amisys assigns priority to the denials and as such all denial codes may not be listed. The payment hierarchy is as follows: system edits, membership, providers, benefits and pricing.

3. Keying errors for two provider claims incorrectly resulted in deductibles being applied. One claim had an $0.08 deductible and one claim had a $1,500 deductible. Furthermore, PHPT did not pay the provider for one claim because the allowed amount and the deductible were equal.

   PHPT's Response: Management concurs. Keying errors will continue to occur as long as there is manual claims entry. Temporary employees staff this vertexing department (data entry) department and this employee is no longer with the company. The use of EDI has significantly reduced the number of manual errors made.

E. Withhold, Deductible and Copayment Testing

1. The purpose of "withhold testing" is to determine whether amounts withheld from provider payments are in accordance with the provider contracts and are accurately calculated. PHPT does not withhold a percentage of payments from providers.

2. The purpose of testing deductibles and copayment is to determine whether enrollees are subject to out-of-pocket payments on certain procedures, whether out-of-pocket payments are within liability limitations, and whether out-of-pocket payments are accurately calculated in accordance with Section 2-3.k. of the TennCare Contract.

   a. On October 9, 1996, PHPT received approval from the Bureau of TennCare to implement its "alternative deductible/co-payment schedule to become effective January 1, 1997." PHPT's uninsured and uninsurable enrollees pay no deductible and the copayment is as follows:

   - Prescriptions $ 5.00
   - Office Visits $ 15.00
   - Non-emergency Use of the Emergency Room $ 25.00

   PHPT requested and received written approval from the Bureau of TennCare for changes to enrollee benefits related to deductibles and co-payments. PHPT filed a request with TDCI requesting a material modification to its certificate of authority for changes to enrollee benefits. This request was made on January 17, 2000, and was approved by TDCI in a letter dated January 31, 2000.

b. One claim was originally denied and then manually approved. When this claim was approved, the copayment was not applied. This error was a manual oversight, not a system problem.

PHPT's Response: Management concurs. The member copay is configured in the Systems Support department and the claims department does not have security access to override this field. The payment of copays is no longer manual and the configuration has been audited and is correct.

F. Pended/Unprocessed Claims Testing

The purpose of testing pended claims is to determine the existence of claims that PHPT has pended, the principal reasons for the pended claims, the number of pended claims that are over 60 days old, and whether a potential material unrecorded liability exists. PHPT provided the examiners a HCFA 1500 and UB 92 pended claims report as of February 28, 2001. A total of 22,035 pended claim lines were reported. Claims in process for more than 60 days totaled 64. As a result, PHPT was out of compliance with Section 2-18 of the TennCare contract, which requires all claims to be processed within 60 days. However, it was noted that claims in pend status included new claims that had not been adjudicated as well as claims that had previously been adjudicated and reopened for adjustment. Adjusted claims did not receive a new claim number. The oldest claim on the pend report was received January 12, 1999, but that claim had been previously adjudicated and then later pended for an adjustment. Previously adjudicated claims included 55 of the 64 claims over 60 days old. Most claims on the pended report were less than 30 days old. These facts, in combination with the minimal number of claims in excess of 60 days old, does not indicate that a potential unrecorded material liability existed as a result of pended claims.

PHPT's Response: Management concurs. Claims are not currently pending over 60 days.

TDCI Rebuttal: The prompt pay analysis of all pended medical claims as of July 31, 2002, indicated that 289 service lines for medical claims were aged over 60 days; however, PHPT was in compliance with the prompt pay timeliness standards for July 2002.

G. Explanation of Benefits (EOB) Testing

The purpose of EOB testing is to determine whether uninsured and uninsurable members (non-Medicaid) who are subject to deductibles and copayments are

provided an explanation of benefits in accordance with usual and customary health care industry practices.

PHPT provided EOBs to enrollees whose claims were subject to cost-sharing liabilities. The examiners requested EOBs for 17 claims tested. PHPT provided 9 EOBs in which no discrepancies were noted. PHPT did not provide 8 EOBs. Per the PHPT TennCare Director, these EOBs could not be provided because they could not be "unarchived" at Perot Systems. PHPT was unable to locate 3 EOBs by member number.

PHPT's Response: Management concurs. EOB's for TennCare members are no longer being produced.

TDCI Rebuttal: Usual and customary health care industry practice requires EOBs be provided to enrollees subject to deductibles and/or copayments to notify them of their cost sharing liabilities.

H. Remittance Advice Testing

The purpose of remittance advice (explanation of plan or EOP) testing is to determine whether remittance advices sent to providers accurately reflect the claim information processed in the system.

The examiners requested 5 remittance advices for testing. PHPT provided 4 of the requested remittance advices and the examiners noted no discrepancies. PHPT did not provide 1 remittance advice. Per the PHPT TennCare Director, PHPT was unable to provide this EOP due to tape damage at Perot Systems.

PHPT's Response: Management concurs. Remittance advices should be sent to all providers, even if no check is produced. The report indicates that the Perot file was corrupt and we could not reproduce the RA.

I. Analysis of Canceled Checks

The purpose of analyzing canceled checks is to: (1) verify the actual payment of claims by PHPT; and (2) determine whether a pattern of significant lag time exists between the issue date and the cleared date on the checks examined.

The examiners requested 5 checks for testing. All 5 checks cleared the bank account within a reasonable time of the issue date.

J. Comparison of Actual Claim Data with System Claim Data

The purpose of comparing hard copy claims with the data entered into the claims system is to ensure that the claims data received by PHPT is accurately entered into the claims system for proper claims adjudication and encounter data reporting to the TennCare Bureau.

The examiners requested the 60 original claims selected for testing. PHPT provided copies of all 60 of the claims. The data elements from the 60 claims were compared to the data elements entered into PHPT's claims processing system. For 7 claims, all diagnoses recorded on the hard copy of the claim were not recorded in the Amisys system. PHPT staff indicated that a system constraint resulted in the examiner's inability to view these diagnoses.

PHPT's Response: Management concurs. There is a system limitation in Amisys for the entry of diagnosis codes. Claims received with more than 5 diagnosis codes are pended. There is now a process/workflow in place that will allow for manual entry of more than 5 diagnosis codes into a separate program/database that will ensure the correct DRG is paid.

K. Electronic Claims Capability

Amendment No. 3 to the TennCare contract revised the third paragraph of Section 2-18. to state: "The CONTRACTOR shall have in place a claims processing system capable of accepting and processing claims submitted electronically with the exception of claims that require written documentation to justify payment…". Section 2-2.g. of the TennCare Contract required the MCO to move to electronic billing no later than January 1, 1997. The electronic billing of claims allows the MCO to process claims more efficiently and cost effectively. PHPT has implemented an electronic billing option for claims submission by providers.

VII. REPORT OF OTHER FINDINGS AND ANALYSES – CLAIMS PROCESSING

A. Weekly Claims Processing Reports

The February 24, 2001, weekly claims processing report was selected for review and the examiners requested PHPT to provide supporting documentation for this report. The examiners noted no discrepancies in their review of the report.

B. Provider Complaints Regarding Claims

PHPT did not respond timely to appeals received from providers. The TennCare Division staff reviewed 82 provider appeals from PHPT's Year 2000 "TennCare Process Log." From this selection, PHPT resolved 27 appeals in 60 days or less. The remaining 55 appeals took longer than 60 days to resolve.

TCA 56-32-226(b)(2) states the following:

> If a provider's claim is partially or totally denied in a remittance advice or other appropriate written notice, then the provider may send a written request for reconsideration to the health maintenance organization within sixty (60) days of the receipt of the partial or total denial of the claim. The reconsideration request should include any documentation or information requested by the health maintenance organization. The health maintenance organization must respond to the reconsideration request **within sixty (60) days after receipt of the request** [emphasis added].

PHPT's Response: Management concurs. Beginning in August 2001, we have expanded our Appeals Department to include a nurse reviewer, 2 claims processors and 2 departmental assistants. This allows the appeals to be reviewed and processed all within the department. Having everything under the control of the Appeals Department allows us to maintain the provider appeals responses to the under 60 days turn around time standard.

C. Provider Manual

The provider manual outlines written guidelines to providers to assure that claims are processed accurately and timely. In addition, the provider manual informs providers of the correct procedures to follow in the event of a disputed claim. A review of PHPT's Policy and Procedure Manual revealed no weaknesses.

VIII. REPORT OF FINDINGS AND ANALYSES – FINANCIAL REVIEW

This examination included a review of account balances on the NAIC Annual Statement to determine if balance sheet and income statement amounts were properly reported as required by NAIC guidelines and Tennessee Code Annotated.

Examiners also reviewed subsequent events to determine if significant changes in accounting estimates were necessary.

A. Analysis of Account Classification

1. Detail of Write-ins – Liabilities

PHPT reported the following as other write-ins to the liabilities as of December 31, 2000:

- Reserve for Transplants $2,959,084
- Accrued Run Out Cost $5,485,000
- Reserve for Contingent Operating Losses $7,728,499
- Grier Decree Reserve $2,079,000

During the examination, PHPT provided the following explanation for the write-ins:

> **Reserve for Transplants** – The reserve for transplants is for costs that will be incurred when an organ or other transplant is performed. The expenses are only accrued on enrollees deemed medically eligible and placed on perspective transplant lists.
>
> **Accrued Run Out Cost** – Although PHPT remains committed to continued participation in the TennCare program, legislative funding issues and the status of the HCFA waiver causes concern regarding the future stability of the program. In response to this concern, management felt it was prudent to accrue the run out cost that would be experienced in case of program departure or termination.
>
> **Reserve for Contingent Operating Losses** – PHP recognizes loss contract liabilities on its commercial lines of business due to GAAP requirements. To be consistent across all lines of business, a reserve for loss contracts (reserve for contingent operating losses) was established on PHPT. This liability recognizes that future medical cost and related expenses will exceed future capitation payments in the current contract period and provides a reserve for that deficiency.
>
> **Grier Decree Reserve –** PHPT staff explained that this liability represents the estimated additional expenses PHP will incur due to the Grier Consent Decree. PHPT calculated this liability at a rate of $1.50 per member per month.

The 2000 NAIC Annual Statement Instructions for the actuarial certification required to be submitted with the NAIC Annual Statement states that the scope

paragraph of the certification should list those items and amounts with respect to which the actuary is expressing an opinion. The instructions further state:

> This list should include but not be limited to:
>
> A. Claims Payable (Reported and Unreported);
> B. Provision for deferred maternity benefits, if any and;
> C. Other actuarial liabilities.

The liabilities described above were not included in the scope of the actuarial certification submitted with PHPT's 2000 NAIC Annual Statement as required; thus, the actuary did not express an opinion on these actuarial liabilities.

PHPT's Response: Management concurs. The three liabilities and loss contingency mentioned were actuarially certified for the 2001 NAIC Annual Financial Statement.

2. Pharmacy Rebates

PHPT incorrectly reported rebates from its pharmacy provider as miscellaneous income. These rebates were a return of monies paid to the pharmacy provider and they should have been reported as a reduction in pharmacy expenses.

PHPT's Response: Management concurs. For 2002, pharmacy rebates have been reclassified to offset medical expense on the statutory filings.

3. Medical Expenses

The review of medical expenses revealed that PHPT had reported amounts related to IBNR expense as a single item in the write-ins. IBNR expense should be classified by line item (physician services, inpatient, emergency room, etc.).

PHPT's Response: Management concurs. PHPT was unaware that reporting IBNR as a separate medical expense was incorrect. PHPT will correct for the 2002 NAIC Annual Statement.

B. Review of Account Balances

1. Accounts Receivable

a. The account "Accounts Receivable-UPA" was overstated by $7,721. The account had not been updated to reflect the current receivable balance.

PHPT's Response: Management concurs. Accounts Receivable – UPA was reclassified as a non-admitted Health Care Receivable for the 2000 Amended NAIC Statement.

b. At December 31, 2000, PHPT reported $1,944,661 as an admitted account receivable resulting from the risk sharing agreement with TennCare for the period July 1, 2000 through December 31, 2000. PHPT selected Risk Banding Option 2 which states:

> TENNCARE and the CONTRACTOR share in all gains and losses as defined below:
>
> Losses: For losses up to 10%, the State will pay for 50% of the loss. For losses in excess of 10%, the State will pay the following percentages of loss:
>
> | | |
> |---|---|
> | July 1, 2000 – December 31, 2000 | 90% |
> | January 1, 2001 – December 31, 2001 | 90% |
> | January 1, 2002 – December 31, 2002 | 80% |
> | January 1, 2003 – December 31, 2003 | 70% |
>
> Gains: For gains up to 10% of TennCare revenue, the State will be paid 70% of the gain. For gains in excess of 10%, the State will be paid the following percentage of gain:
>
> | | |
> |---|---|
> | July 1, 2000 – December 31, 2000 | 90% |
> | January 1, 2001 – December 31, 2001 | 90% |
> | January 1, 2002 – December 31, 2002 | 80% |
> | January 1, 2003 – December 31, 2003 | 70% |

Based on the risk share formula set forth in the TennCare Contract, PHPT's accrual of a $1,944,661 was reasonable.

2. Claims Payable

A review of claims run-out expenses through April 30, 2001, indicated that the amounts reported as claims payable at December 31, 2000, were adequate to cover actual expenses.

PHPT reported claims payable of $27,962,312 as of December 31, 2000 which was the balance certified by PHPT's actuary in the actuarial certification submitted with the 2000 NAIC Annual Statement.

3. Long-Term Investments

A review of the amortization schedule supporting the discounts on Long Term Investments revealed that the life of some of the bonds was not properly calculated. This error resulted in an immaterial difference in the bond valuation. PHPT corrected this error in early 2001.

IX. PROVIDER AGREEMENTS

The examiners reviewed five provider agreements to determine if they contained the language required by Section 2-18 of the TennCare Contract. No deficiencies were noted.

X. SUBCONTRACTS

A. Compliance with TennCare Contract

Section 2-10 of the TennCare Contract requires all subcontracts to be approved by the TennCare Bureau. During the examination period, PHPT's subcontracts that required TennCare approval were as follows: Doral Dental, Express Scripts, Quality Transportation and PHP (PHPT's parent company). The TennCare Bureau confirmed that PHPT had properly submitted the Doral Dental, Express Scripts, and Quality Transportation subcontracts for approval in accordance with Section 2-10 of the TennCare contract.

PHPT had not submitted its administrative services subcontract with PHP for approval with the TennCare Bureau. Therefore, PHPT did not comply with Section 2-10 of the TennCare contract.

PHPT's Response: Management concurs. A service agreement between PHP Companies, Inc. and Preferred Health Partnership of Tennessee, Inc. was executed on 1/1/2000.

B. Payments to Subcontractors

Examiners tested all payments made to subcontractors between July 2000 and December 2000. PHPT did not always pay subcontractors timely based on the contract requirements. Of the 17 payments to Express Scripts, twelve were not paid in accordance with the contract requirements. Of the nine payments made to Quality

Transportation, three were not paid in accordance with the contact requirements. Of the sixteen payments made to Doral Dental, three were not paid in accordance with the contract requirements.

PHPT's Response: Management concurs. In attempts to increase the turn around time for payments to subcontractors, PHPT has implemented e-mail approvals for invoice payment.

XI. TITLE VI

Effective July 1996, Section 2-25 of the TennCare Contract required PHPT to demonstrate compliance with Federal Title VI of the 1964 Civil Rights Act that prohibits discrimination based on race, color or national origin. Based on discussions with various PHPT staff and a review of policies and related supporting documentation, PHPT was found to be in compliance with Section 2-25 of the TennCare Contract.

XII. HMO HOLDING COMPANIES

Effective January 1, 2000, all HMOs were required to comply with TCA § 56-11 Part 2 – the Insurance Holding Company System Act of 1986. TCA § 56-11-205 requires that "Every insurer and every health maintenance organization which is authorized to do business in this state and which is a member of an insurance holding company system shall register with the commissioner…Any insurer or health maintenance organization which is subject to registration under this section, shall register within fifteen (15) days after it becomes subject to registration and annually thereafter by April 30 of each year for the previous calendar year…" As of the end of fieldwork, PHPT had not made the necessary registration under this law. However, subsequent to fieldwork, PHPT filed this registration.

PHPT's Response: Management concurs. Preferred Health Partnership of Tennessee, Inc. HMO Holding Company statement was received by TDCI on June 19, 2001. This was submitted by John Everett, Director of Compliance.

XIII. MEDICAL LOSS RATIO

Section 3-10(c)(1) of the Contractor Risk Agreement requires all TennCare MCOs "to achieve an annual medical loss ratio of no less than 85% of capitation payments received from TENNCARE based on a calendar year as an accountability measure for Fiscal Year 2001 while new accountability measures are being developed. . . .The intent of the 85% medical loss ratio is that 85% of the capitation rate will be spent on covered medical services for eligible TennCare enrollees."

Per the Medical Loss Ratio ("MLR") reports submitted to the TennCare Bureau, PHPT reported an MLR in excess of 85%.

The examiners hereby acknowledge the courtesy and cooperation of the officers and employees of PHPT.